



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KIRT REPP DC
PO BOX 9973
THE WOODLANDS TX 77387

Respondent Name

WAL MART ASSOCIATES INC

Carrier's Austin Representative

Box Number 53

MFDR Tracking Number

M4-13-1228-01

MFDR Date Received

JANUARY 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the carrier should have reimbursed for the correctly coded 95903 and 95904 NCS charges because they were medically necessary and billed correctly."

Amount in Dispute: \$2,530.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The self-insured has until 02-15-13 to take final action on the request for reconsideration. This request is not subject to MDR at this time."

Response Submitted By: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2012	CPT Code 95903 (X4)	\$295.00/each	\$486.17
	CPT Code 95904 (X6)	\$225.00/each	\$551.02
TOTAL		\$2,530.00	\$1,037.19

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 *Texas Register* 364, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 9-Code not defined on EOB.
- 906-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.

Issues

1. Is CPT code 95903 and 95904 bundled in another service billed on the disputed date of service? Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for CPT code 95903 and 95904 based upon reason codes "97 and 906."

On the disputed date of service the requestor billed CPT codes 99203, 95861, 95934-50, 95903 and 95904.

Based upon National Correct Coding Initiative edits, the allowance for CPT code 95903 and 95904 are not included in the allowance of another procedure billed on this date; therefore, the respondent's denial based upon reason codes "97 and 906" are not supported. Therefore, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77076, which is located in Houston, TX Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

Using the above formula, the Division finds the following:

Code	Calculation for Locality 0440218 Houston	Maximum Allowable
95903	(54.86/34.0376) x \$75.41 for 4 Units	\$486.17
95904	(54.86/34.0376) x \$56.98 for 6 Units	\$551.02
		\$1,037.19

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is \$1,037.19.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,037.19 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

9/13/2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.